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ABSTRACT

This paper is an exploration into the multiple levels and dimensions of the familiar reactions to former mental patients. A form of the Incomplete Sentence Blank Test (ISB) is presented as an instrument to reach beyond the unidimensional restrictions of standard measures, which tend to ask respondents about abstract, hypothetical implications and deficiencies of the ISB for mental health research are explored. The findings suggest that families do carry a heavy burden. Although the majority of respondents do not express feelings of shame or strong wishes for social distance from the former patient, feelings of being trapped, antagonistic, and burdened by his presence are prominent. These reactions are most pronounced in those families attempting to cope with a kin perceived as still severely handicapped and those who have been hospitalized three or more times. (Author)

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AN INVISIBLE CRISIS: THE BURDEN OF FAMILY COPING WITH THE MENTALLY ILL AS AN UNINTENDED CONSEQUENCE OF DEINSTITUTIONALIZATION

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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What of the family in this era of deinstitutionalization? The major shift in the nation's public treatment of its emotionally disturbed members from a hospital-based to a community-centered system has had, to different degrees, massive reverberations through all levels of the mental health system. One unintended and little noticed impact of the phasing out of public mental hospitals across the nation is the vastly increased emotional and interactional burden which the families of the former patients will now be carrying.

Of all the formal and informal institutions that are and will become involved with the community treatment of the mentally ill, the family now becomes a major direct link in the process. The spouses, parents, and other kin now caring for the former patients have suddenly become, unwittingly, and indeed sometimes unwillingly, the de facto therapists. While more patients are now at home, fewer families may have available the organizational supports (public hospitals) once relied upon, and the new community agencies may not as yet have become fully operational. At what cost to their own personal and familial stability -- and to their consequent ability to adjust to the returning patient, and he to the post-hospital world?

This paper focuses on this critical component of the emerging treatment network -- the families of former patients -- to examine the nature of the coping process of families charged with the burden of the mentally ill. This new movement to community-based care -- a movement which began soon after World War II with the efforts to "humanize" hospitalization, (Bockanen, 1957) accelerated with the introduction of chemotherapies in the 1950's, (Angrist, 1968) and was finally acknowledged as the keystone of mental health policy with President Kennedy's call for the creation of community mental health centers in 1963, (Glascote, 1969:1) -- now implicitly but undeniably pulls the families of the mentally ill into a critical treatment role (Lefton, 1970). No longer has the family solely an aetiological part in the

patient's problem nor are they merely the initiator of treatment, handing the patient over to the hospital authorities and withdrawing from responsibility. Medical World News (1974) reports that upwards of 250,000 former patients will now be remaining in the community for treatment and most of them will be living with families. Directly, then, and continually, parents, spouses, and other relatives must bear the day-to-day burden of coping with mentally ill kin -- many of whom, under the old regime might still warrant hospitalization.

The accelerating discharge of patients that began to occur in the late fifties and early sixties led researchers towards an exploration of the ex-patient's post-hospital adjustment, Freeman and Simmons (1961, 1963), for example, and, a few years later, Angrist, et. al (1968) focused on the performance levels of the patients and acceptance by the family. The focus of these studies was on the patient himself -- his psychiatric functioning, his domestic and social performance, and the relationship between functioning and rehospitalization. The operational assumption had it that length of community tenure without rehospitalization was itself a good index of the patient's adjustment to the family and to his community.

The concern with adjustment to the post-hospital world was central to the wide range of studies revolving around the notions of stigma and the mental patient identity (Goffman, 1963; Kreisman and Joy, 1974). Behind these investigations was an assumption that any individual who evokes shame or fear among those with whom he lives cannot be living within a supportive environment conducive to successful rehabilitation. And thus stigma and social distance could be taken at least implicitly as an indication of adjustment and non-adjustment.

Generally, the studies of stigma found it not to be a problem. Freeman and Simmons (1961) found only 24 per cent of their sample of relatives felt any shame around the former patient's presence in the home. Cumming and

Cumming (1965) used a case approach in finding that families did indeed experience a stigma, but concluded that the stigmatizing identity was reversible upon acceptable role performance. A number of other studies, focusing on either the former patient's feelings of being stigmatized (Gove and Fain, 1973; Swanson and Spitzer, 1970), or on relatives feelings of shame (Crocetti, et. al, 1974), have consistently found the "mentally ill" label not to be an obstacle in their adjustments.

Schwartz and Meyers (1973) applied the standardized Whatley Social Distance Scale (1959) to the attitudes of family members and reported that in almost every case some feelings of social distance were found. However, on six of their eight social distance items between 87 per cent and 98 per cent expressed favorable attitudes, and between 65 per cent and 77 per cent of their sample indicated low social distance on the other two items.

In a similarly accepting vein, a number of studies have reported relatives pleased with, or looking forward to, the patient's return and Dunigan (1969) found a willingness to accept the female former patient after one or two hospitalizations, but excluding after more hospitalizations.

However, we cannot infer an agreeable, mutually supportive home environment merely from the absence of such attitudes as shame or avoidance. While the label "mental patient" may not poison the familial welcome, particular interactional or psychiatric qualities of the former patient may be troublesome or uncomfortable to the family. Likewise, wanting the kin to come home cannot mean that his presence is a generally uninterrupted pleasure. Investigations of the former patient's social identity and studies of the importance of the disturbed kin to the family pin-point critical corners of the post-hospital context, but they do not zero in adequately on the emotional impact on the family of actually coping with the formerly hospitalized.

What is lacking is an attempt to spell out more fully the impact, the

costs, the burdens to the family of maintaining the former patient in the home. Kreisman and Joy, in their extensive review of the literature on family response to mental illness conclude that "... the process of accomodation to recurrent or prolonged disturbance in family life is virtually uncharted (1974:42).

Several researchers, however, have headed in this direction. Grad and Sansbury (1963) explore the effects of the patient's illness on the family, seeking the burden the patient's presence put on the household routines, social and leisure activities, and the employment of other members of the family. They found that "at least one-fifth of these families have had a severe problem of management of one kind or another; either domestic routine of their households was upset, their social life and work interferred with, their health affected, or their incomes reduced" (1963:312).

With the exception of the dimension of affect on health, Grad and Sansbury's focus was on the burden on "objective," functional tasks of family living, such as household routine, rather than the more subjective emotional cost of coping. Hoening and Hamilton (1966;1969) went a step further, separating burden into an objective component and a subjective one. The objective included (as did Grad and Sansbury) "a number of adverse effects on the household," but they also included "any type of abnormal behavior" because "it was assumed that if such behavior was present more than occassionally, this would constitute some burden on the family" (1966:167).

The subjective component they defined very broadly as "what the relatives themselves felt about it (the burden) and to what extent they considered they had carried any burden" (1966:170). From their families' responses, the authors estimated that 69 per cent of the former patients had created at least one difficulty for their household routine (objective burden). On the subjective side, only 9 per cent complained of a severe burden, 51 per cent

admitted some burden, and 43 per cent felt they had endured no subjective feelings of burden. In addition, the total amount of objective burden was "considerably greater" than the subjective burden (1966:171) -- suggesting that disruption of the familial routine is not necessarily subjectively experienced by the families as a burdensome problem.

The intent of this paper is to carry the Hoenig and Hamilton analysis one step urther by attempting to 1) specifically delineate some of the affective dimensions of the burden subjectively felt by significant other relatives; 2) attempt to allow the sample of significant others to determine these subjective dimensions of coping; and 3) relate these subjective dimensions to certain demographic conditions of the families and psychiatric characteristics of the former patients.

Probing the Dimensions of Subjective Burden: The ISB

To explore in some depths the affective dimensions of familial coping, we modified a form of the Incomplete Sentence Blank Test (ISB) developed by Rotter and Williams (1947; Doll et. al., 1975). Unlike other instruments which provide either hypothetical or general situations for respondents to react to (e.g., "It is best not to associate with people who have been in mental hospitals," Whatley, 1959; Schwartz and Meyers, 1973), or explore single dimensions predetermined by the researcher (e.g., Freeman and Simmons Shame Scale, 1961), the ISB allows the dimensions relevant to the respondents themselves to emerge within a survey framework, rather than being assumed from the start by the researcher.

The respondent is asked to verbally complete a series of sentence stems (e.g., my greatest problem...; My (son's) behavior...; Former mental patient's...; Our family...) while the interviewer records the completions. The instrument allow the complex, ambivalent, often inconsistent reactions which are

obviously the substance of much of the daily machinations of trying to cope with the mentally ill. The ISB stems were administered verbally by the interviewer as part of a larger attitude and adjustment questionnaire.

The contents of the completed protocols were analyzed individually by the authors, and the overall conclusions discussed so as to arrive at consensus about the general orientation of each respondent. The ISB protocols were then coded as to the presence and degree of four factors which had emerged most prominently and frequently during the process of analyzing and scoring the content of the completions.[1] These four dimensions were the following:

1. Problematic: A respondent's completions often indicated that the presence of the former mental patient in the family was a significant interference to the family. Any indication or sense from the protocol that the former patient was either a noticeable emotional, or financial burden, or a definite obstacle to the normal household routines was considered evidence of a problem.

2. Sympathy/Unsympathy: Expressions of varying degrees of sympathy or antagonism and resentment towards the former patient or his presence. Respondents might react with understanding, sympathy, caring, "going towards" the ex-patient, wanting to help him adjust, or, at the other end of the continuum, they "moved away" from him emotionally, be cold, lack of concern, express bitterness or resentment.

3. Inclusion/Exclusion: Completions which brought out a willingness to bring back and keep the former patient within the family fold, as opposed to others which blatantly expressed a wish to exclude the patient.

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[1] Originally we were scoring six dimension. But two factors -- shame at the former patient's presence, and denial of problems in the face of severely disturbed behavior -- were scored rarely and, even when suggested for a protocol, their presence was often very ambiguous and open to much disagreement.

4. Not Trapped/Trapped: A number of protocols revealed sometimes directly, but more often obliquely -- that the S.O. felt burdened, trapped by returning kin's presence, helpless, often accompanied by feelings that there was no where they could turn.

We propose these first results as an initial effort to probe the multiple textures of meanings and reactions to a mentally ill kin -- reactions beyond the limits of conventional standard instruments. Very often the presence and degree of these factors did not reveal themselves through any specific statement. Instead, the scorers had to "listen" for the feel, the sense, the general tone between the lines, so to speak, of an entire protocol.[2]

Characteristics of the Sample and of the Former Patients

Home interview data was collected from 125 significant others (spouses, parents, or other relatives) with whom patients recently released from three state hospitals were living. The interviewed sample was 60 per cent white, 40 per cent black, 55 per cent female, high school educated with a mean age of 51. On the Hollingshead scale, 76 per cent occupy the lower socio-economic classes IV and V, and have a family income of $9,000.00 a year or less (20 per cent earned $3,000 or less).

Of the former patients, well over half (68 per cent) are multiple admissions, with 56 per cent having had three or more hospitalizations, and 5 per cent (N=6) with ten or more hospital stays. Over sixty per cent of these former patients are rated by their relatives as performing poorly socially, domestically, or in their occupations.

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[2]While use of the ISB is emphatically exploratory, several reliability checks were run. An intraclass correlation analysis resulted in interrated reliabilities ranging from .50 to .90, with same and denial the only dimensions with coefficients below .80. A Cronbach's alpha ot .62 was found, suggesting some but little relationship among the dimensions.

Few of these patients (fifteen, or 12 per cent) were rehospitalized at any time during the twelve month period in which hospital data was collected. This lack of rehospitalization is particularly unusual, since the patterns in other research seems to be that the largest proportion of returnees are readmitted during the first six months (Angrist, 1968:80), and we would expect abundant early readmissions among a predominantly chronic population such as we were studying.[3]

The Dimensions of Affective Burden

Almost three-quarters of the protocols indicated that the former patient kin continued to be a problem to the family.[4]

(Table I About Here)

For example, one husband admitted:

What annoys me most is her persistent mental problems. Another complained of "My wife's filthy housekeeping." while a third said:

> A mentally sick person is a damned lot of frustration....(Her) behavior is exasperating....Strange behavior looks pretty normal to me now where _____ is concerned.

On the other hand, while a strong majority said the former patient was felt to be a burden in the sense of being difficult to cope with few expressed what we could code as intense antagonism (16 cases, or 13 per cent of the total) -- and the same number we considered highly symapthetic and sup-

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[3]The field work for the present study was completed approximately six months before the only public facility for lon term chronic patients in the area (Cleveland, Ohio) was closed. We cannot presently assess, therefore, the impact of the hospital's closing on the familial burden of coping. Nevertheless, it seems plausible that any difficulties will only be intensified, in the succeeding period marked as it is by -- at worst -- the absence of familiar, reliable hospital as a source of help, or -- at best -- the overcrowding, therefore, less available (and often less geographically accessible) alternative hospitals.

[4]On the other hand, most (68 per cent) of those who were considered a problem on the ISB were not considered management problems, interfering with the normal routines of the family around the house. There would seem to be, then, other ways of being experienced as a problem besides being a household interference.

portive (N=14, 17 per cent). The majority (72 per cent, N=89) came across as ambivalent, with various completions conveying a sense of concern and caring mixed with resentment and anger at the difficulties this disturbed kin brought back to the home.

At the extremely antagonistic end, the husband who above accused his wife of filthy housekeeping, went on to say:

> A mentally sick person is the worst person in the world to live with....Former mental patients turn out to be killers....Her behavior is terrible, suspicious....Her friends don't even come by anymore....

Others, such as one father on his son, were more understanding:

> Former mental patients are no different and should be given an equal chance socially and in work.

Or, a mother about her son:

> Our family is going to do the best we can for _____ ....What annoys me most is the frustration of not being able to help_____.

Another mother, recalling that day right before the interview when her son was readmitted for the fifth time, expresses that very understandable ambivalence of concern, sadness, affection, mixed with bitterness, exasperation and relief at his rehospitalization:

> Last Sunday...must have been a very miserable day for him...A mentally sick person is a very frustrated and unhappy person...My greatest fear is that he will (n)ever be able to function as a normal human being... he needs help and friendship...What annoys me most is his obscene languate, his yelling, throwing, and his bad attitude toward his sister and dad...If he had taken his medication he would have been able to live more normally...

One other mother felt that her son:

> is a very selfish, sick person...(But) my greatest fear is to die and leave him with selfish people because I am terribly sorry for him...

The persisting problems which are the source of the ambivalent sympathies that relatives feel towards these spouses, children, and other kin extend to a dominant uncertainty about how much interaction the significant other wanted with this former patient. Very few wished for total exclusion from the family

(6 per cent, N=7), while slightly more than a quarter of the sample (27 per cent, N=33) came across as highly including. The majority (67 per cent, N=82) were ambivalent, sometimes wanting to bring the former patient back into the fold, and in the next completion wishing he were out of the house or they were away from it all. One wife's acceptance of the situation --

> (His sickness) is something we have to cope with and do the best we can...(for) a mentally sick person is one who needs help...

-- is coupled with annoyed suggestions that she wished he would not be such a bother:

> ...He cannot work and just sits around for hours doing nothing...I secretly wish that he wouldn't get sick again...

More obviously excluding was a sister who said:

> I secretly wish to get away from all myself...Last Sunday, what she did I don't know. I stay away from her and I told everyone else I know to stay away from her...

At the more including end, on the other hand, is a mother whose stem completions strongly suggest that she tries to keep her son part of the family:

> Our family is going to do the best we can for _____.

The fourth dimension, indications through the stem completions that the respondent felt trapped by the former patient's presence, came across in almost half the protocols (44 per cent, N=54). A few times the expressions were relatively direct: One wife's sickness

> is a terrible burden...

or, a husband's fear that

> ...this will go on forever...

But much of the time the feelings of helplessness, permanent entrapment came across as a <u>leitmotif</u> throughout an overall protocol. The comments of the excluding sister, mentioned above, who wished to get away from her disturbed brother, were also taken as clues to feelings of frustration and hopelessness.

Similarly, the husband whose greatest fear was that "this will go on forever" seems to be telling us that he sees his predicament with his wife whose behavior "is exasperating" as - without hope and without end. Indeed, his only hope seems to be her eventual death:

If things go on like they are, she'll just die in bed...

These selected completions, culled from the 125 protocols, should give some feeling of both the nature of the ISB data and the intensity of the feelings in many cases. Many of these families live under tremendous burdens, burdens which are expressed to some extent, through the stem completions.

Demographic and Psychiatric Correlates of Affective Burden

Does any particular age, sex, or educational group experience these burdens more so than any other? Do such factors as social class or the closeness of the relationship to the former patient affect the nature or extent of the subjective burden felt by these relatives? Apparently not. In analyzing the four dimensions of affective burden by a selection of demographic categories (See Table II), we found no significant, or even substantial relationships. In other words, the burdens of coping with the mentally ill are universal, with no respect for differences in social class, education, the age nor the sex of the respondent nor of the former patient. Indeed, the closer relatives -- such as parents and spouses -- who one might expect to harbor a greater reservoir of acceptance, were no more or less burdened than the more distant relatives, such as aunts, uncles, sisters, etc.

(Table II About Here)

On the other hand, as would be expected, the burdens are significantly and consistently related to the psychiatric condition of the former patient (See Table III). Relatives who predicted that their kin would need more hospitalizations in the future, and those who perceived him as currently

displaying symptoms were significantly more likely to view the former patient as a problem to feel antagonism, and to feel trapped. And, on the objective criteria of the number of past hospitalizations, those who had been institutionalized more were more likely to be considered a problem and to arouse feelings of exclusion. In addition, there was a trend for an increase in the number of times hospitalized to be related to a lack of sympathy (pg. 11) and to feelings of being trapped (p. 20).

(Table III About Here)

However, substantial numbers of those former patients who are <u>not</u> perceived as seriously disturbed are also burdensome. Of those who are seen as not needing future hospitalization, twenty-six of them (or 33 per cent) are considered a problem by their relatives, and 55 or 68 per cent of those not perceived as displaying symptoms nevertheless come across as a problem.

Relatives gave what we considered highly sympathetic responses to only 22 per cent of those former patients who would not need more hospitalization, while 78 per cent of this subgroup evoked mixed emotions (but none was subject to outright antagonisms).

Likewise, feeling trapped was not confined only to those relatives who saw their kin as still psychiatrically disturbed. Only 11 per cent of those who did not see a need for rehospitalization at some time in the future felt trapped, but 38 per cent of those relatives who reported few signs of symptomatic behavior indicated that they felt trapped. And, moreover, over half of those who said they felt trapped were relatives reporting few symptoms (59 per cent, N=31).

(Table IV About Here)

In short, personal difficulties and dilemmas most decidedly fall to those who must cope with kin who are perceived as still psychiatrically impaired. But even those respondents who see their former patient relative as generally

free from symptoms and capable of avoiding rehospitalization are not spared unpleasant and at time difficult burdens. The bottom line seems to be that, for this sample of relatives caring for previously hospitalized kin, the post-hospital familial experience is more likely to be painful than rewarding and reuniting.

Discussion and Conclusions:

The intent of this paper has been to delineate and convey some of the more latent, underlying dimensions which comprise the affective core of the process of familial coping with the mentally ill.

There are methodological difficulties with using as projective an instrument as the ISB -- on the whole we must take the respondent's statements at face value; we must judge without benefit of the tones with which the completions were made; the possibilities that the dimensions of burden generated are too dependent on the particular scorers; and, indeed, the very subjective nature of the scoring of the instrument. But, even in its initial, exploratory stages the ISB seems to undeniably bring to the surface an obvious, but neglected, yet critical fact about post-hospital adjustment: that families may be placed in an emotionally demanding and untenable situation. There is a certain face validity in the troubled feelings expressed in many of these completions. These families are indeed burdened in their efforts to cope. Rehospitalization may be too stigmatizing or psychiatrically unwarranted, yet serious problems of coping remain. It would seem both theoretically and practically important that the nature of these burdens be brought to the surface and examined.

If, indeed, the post-hospital home environment may be punctuated by the emotional burdens and strains that we have reported, then the meaning of "Successful discharge" is thrown into question. We have here a substantial

number of chronic former patients whose symptoms are not perceived to be under control and who present definite coping difficulties to their families -- and yet these patients are not rehospitalized. They remain in environments marked by antagonism, isolation, at times by fear, resentment, bitterness, and other such reactions which are a far cry from what would usually be considered a context conducive to continued recovery and successful adjustment. Nevertheless, by the very fact that they are not back in the hospital, they would be considered by many researchers and administrators as "successful" discharges (See Meyer and Rosenblatt, 1974 and Arnhoff, 1975: 1280 for a more extended discussion of this point).

Thus, the customary methodological and psychiatric measure of "success" -- lack of rehospitalization -- needs refining. More attention, and more sophisticated analysis, must be paid to the quality of that lack of rehospitalization, else "discharge" becomes an almost meaningless category on a hospital record.

The Parsons and Fox argument of the early fifties (1952) that American families are not structurally capable of coping with the seriously handicapped and maintaining equilibrium runs directly counter to the current thrust of mental health policy, with its implicit return of responsibility to the family. Yet the data presented here would seem to support the more pessimistic predictions of Parsons and Fox: here are a sample of families whose functioning at several levels would seem to be seriously damaged by having to care for the mentally ill.

Many of the writings and studies of the fifties and sixties argued that families in fact were malleable and would tolerate a great deal of deviant behavior both before and after hospitalization (Clausen and Yarrow, 1955; Schwartz, 1957; Freeman and Simmons, 1963; Vincent, 1967; Angrist, et. al., 1968). But there is an important distinction between tolerating deviant behavior and accepting it. Psychiatrically disturbed behavior may be tolerated

in that its display does not spark rehospitalization or moves to expell the former patient. But to "put up with" the behavior does not mean that these symptoms do not exact a price of the family. Our data suggests that these symptoms are put up with, but they carry a very strong negative charge and may have serious emotional impacts upon the family.

One result of the shift from hospital-based to community-centered treatment is the placing of families in a situation of forced accomodation. With the absence of the usual routine mechanisms and pathways linking families to relief, many families may be forced to tolerate behaviors that previously would have led to rehospitalization. While toleration may be heightened, this in no way means that acceptance will be also. Will forced toleration intensify the burdens of coping with the chronic patient? Or -- has the presence of ready help-sources in the past made it easier for families to indulge harsher feelings because they can always get rid of the troublesome member?

Arnhoff has recently argued that the policy of massive deinstitutionalization "is based on the logical fallacy that since bad hospitals are bad for patients, any hospitalization is bad for patients and should be avoided or made as short as possible" (1957:1278). But, he goes on, this policy tends not only to exacerbate patient problems but is carried on at considerable social costs -- as our data suggests here. "This policy," he concludes," will eventually lead to the need to rediscover the public mental institution... since there unfortunately remain large numbers of chronic psychotics who are unable to exist outside of an institutional setting" (1957:1278).

In sum, the paradox of the enlightened move towards a community care system is that, rather than simplifying and humanizing the treatment process, it has immeasurably complicated it. Rather than removing treatment to a more civilized and benign setting, it is sending the problems home, which may have devastating consequences for the patient, for his family, and, ultimately, for the community mental health movement. 17

TABLE I

Affective Dimensions of Familial Coping
Generated Through the Incomplete Sentence Blank Test

ISB Variable	Cases	Percent
ISB Sympathy		
High	17	14
Moderate*	89	72
Low	16	13
ISB Problem		
No	32	26
Yes	90	74
ISB Include		
High	33	27
Moderate*	82	67
Low	7	6
ISB Trapped		
No	68	56
Yes	54	44

*Moderate sympathy (or unsympathic) and moderate inclusion (or exclusion) are categories best interpreted as containing ambivalent and/or contradictory feelings by the respondent towards the former patient.

TABLE II

Demographic Correlates of the Affective Dimensions of Familial Coping (Gamma or Phi Coefficients)

Demographic Factor	ISB Problem	ISB Sympathy	ISB Trapped	ISB Include
Respondent's Age	γ = .11	γ = .01	γ = .02	γ = .08
Education	γ = .11	γ = .10	γ = .02	γ = .14
Sex	φ = .16*	γ = .03	φ = .00	γ = .05
Race	φ = .01	γ = .03	φ = .01	γ = .01
Income	γ = .20	γ = .12	γ = .16	γ = .14
Social Class	γ = .04	γ = .01	γ = .00	γ = .21
Former patient's Age	γ = .13	γ = .10	γ = .06	γ = .07
Education	γ = .11	γ = .11	γ = .03	γ = .13
Sex	φ = .16*	γ = .10	φ = .10	γ = .02
Closeness of Relationship	γ = .17	γ = .21	γ = .13	γ = .02

* $p < .10$

TABLE III

Psychiatric Correlates of the Affective Dimensions of Familial Coping (Gamma or Phi Coefficients)

	ISB Problem	ISB Sympathy	ISB Trapped	ISB Include
Number of Prior Hospitalizations	γ = .45**	γ = .00	γ = .26	γ = .42**
Symptomatic Behaviors	= .16*	γ = .29**	γ = .14	γ = .01
Rehospitalized	ϕ = .11	γ = .02	ϕ = .03	γ = .25***
Respondents feel former patient need further hospitalization	γ = .51***	γ = .57**	γ = .53***	γ = .21

* $p < .10$
** $p < .05$
*** $p < .01$

TABLE IV

Percent of Burdened Respondents Who Felt Former Patient Was Still Disturbed

	Former Patient Needs Further Hospitalization			Former Patient Displays Symptomatic Behaviors	
	Yes	Maybe	No	Yes	No
ISB Problem (Former patient perceived as a problem)					
Yes	84	71	33	85	68
No	26	29	67	15	32
ISB Sympathy (Respondent feels toward the former patient)					
Low	21	5	0	25	7
Moderate	74	79	78	60	79
High	5	16	22	15	14
ISB Trapped (Respondent feels trapped)					
Yes	63	39	11	59	38
No	37	61	89	41	62

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